
FINAL DRAFT

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Executive summary

This report is an evidence-based overview of HIV prevention services targeting African communities in England. The report supports the national policy framework in this area - HIV Prevention and African Communities Living in England: A Framework for Action - which has been developed by the National AIDS Trust and funded by the Department of Health and London HIV Commissioners. The objective of this report is to identify the current strengths and needs of these services, so as to inform the development of HIV Prevention and African Communities Living in England: A Framework for Action. It identifies ways in which providers of HIV prevention services to African communities can be involved effectively with statutory partners at strategic rather than just operational levels.

The findings of this report are based on a sample of providers. Not all providers were interviewed. The evidence was collected through telephone interviews and focus group discussions with a sample of HIV prevention service providers (n=31) across England. From these interviews and focus group discussions it emerged that a range of HIV prevention services available to African communities exist across England, with a majority of these services concentrated in London. This concentration in London reflects the demographic and epidemiological distribution of African communities in England since the 1991 census.

Since the 1991 census, however, which is currently out of date, there has been a shift in the characteristic of the heterosexual epidemic with increasing numbers of people from Zimbabwe, Zambia, Congo, West Africa, South Africa and Uganda using services outside London. The dispersal programme, under the Immigration and Asylum Act (1998), has influenced increases of HIV service use by asylum seekers and refugees affected by HIV outside London. There are also increasing numbers of ‘new’ communities, such as students and other nationals from high prevalence countries in Sub-Saharan Africa settling outside London where HIV health prevention services with African communities were traditionally less prioritised. The challenges are enormous for providers outside the capital, a result of lack of social capital on African cultural issues.

Various organisational structures target specific communities. These structures recognise the diversity of African communities. A provider’s notion of its target community often reflects the level of organisational development and the history of the epidemic within its health authority boundaries. Structures that target communities on the basis of national identity tend to be in the early phases of organisational development with mature agencies describing themselves as having a pan-African remit. Tribal identities appear to have been embedded into nationalised identities. Nearly all community-based and voluntary agencies identified themselves as charities.

For some African communities, the provision of HIV prevention interventions occurs within the broader framework of service provision that addresses citizenship and rights, poverty and deprivation, family dispersal and at times psychological trauma. Prevention activity targeting the
health and social care needs of those living with HIV has become the main emphasis of many providers, accompanying the development of HIV combination therapies. These community-based organisations are reported as under-resourced and their work lacking systematic evaluation, resulting in limited capacity for primary prevention with African communities at large. People living with HIV are less prioritised in primary prevention, in particular reducing the rates of re-infections and onward transmission.

There is evidence suggesting that HIV prevention messages may not be reaching some targeted populations: Africans are presenting late for HIV treatment, some have higher viral loads, and other sexually transmitted infections were reported as being on the increase. Although women are targeted in the antenatal testing programme, there is limited evidence of African men and women (not pregnant) engaged in voluntary HIV-testing. There are reported lower levels of awareness about locally available HIV prevention services amongst the general African population.

London-based agencies reported that their most important resource was cultural competence and an awareness of the cultural practices placing their communities at risk of HIV. Agencies outside London reported a lack of cultural competency. This study has identified the following as limitations of HIV health promotion services:

- limited funding and capacity building
- limited evidence-based interventions
- the HIV health promotion needs of ‘new’ and indeed ‘traditional’ communities remain relatively unexplored
- limited use of traditional modes of communication on intimate issues
- limited inter-agency and inter-regional collaboration
- limited gender specific interventions
- lack of clear guidelines at both strategic and operational levels.

All these limitations are occurring within an environment that is compounded by the persistence of HIV-related stigma.

Recommendations are proposed, all hinged on building the capacity of organisations targeting African communities. Evidence-based HIV prevention interventions should be prioritised with commissioners setting targets and priorities that promote diversity.

User-involvement initiatives need to be incorporated into HIV prevention work, allowing Africans to (re)define their own priorities and solutions on how best to meet complex and evolving HIV prevention needs. Pan-London and regional funding is recommended, as is national funding to support co-ordination and joint working. Inter-agency and inter-regional collaboration requires support. Systematic evaluation of interventions to reflect changing needs and priorities should be prioritised. Marketing strategies need to ‘follow’ where the communities are, with rigorous monitoring embedded in these strategies.

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1 Students, asylum seekers and other newly arrived migrants from high-risk countries.
Key findings

The goal of *HIV Prevention and African Communities Living in England: A Framework for Action* is to reduce the acquisition and transmission of HIV infection amongst African people in England. This mapping exercise has shown that the goal of reducing acquired HIV infections by 25% in 2007, as set out in the *National Sexual Health and HIV Strategy*, may be problematic to achieve, given the current environment within which HIV prevention services targeting African communities are structured in England. To understand these limitations, this report outlines some of the problems faced by providers in reducing the rate of HIV infections amongst African communities in England.

The following were reported as barriers to effective HIV prevention interventions.

**Limited funding and capacity building**

- Many HIV prevention services lack sustained funding arrangements (e.g. the small grants scheme).
- The increasing prevalence of HIV in ‘new’ communities (e.g. students, asylum seekers, Congolese, Kenyans, West Africans, Tanzanians, Zambians and Zimbabweans) has not been matched with equivalent needs assessments and capacity building of organisations targeting these populations.
- There are few Africans in strategic position, for example working as commissioners. This is perceived as leading to less prioritisation of African HIV prevention services in HIV commissioning.

**Limited evidence-based interventions**

- There are concerns that some HIV prevention strategies were directly transplanted from gay to heterosexual African communities without evidence of what the needs of African communities are.
- There is limited evidence of the HIV prevention needs of African communities. Much of the HIV prevention effort examined in this study is undermined by the lack of a systematic examination of sexual behaviour and sexual cultures in African communities.
- Most HIV prevention services lack systematic and sustainable evaluation.
- Although most agencies provided basic HIV awareness and distribute condoms, there are expressed needs to invest in changing attitudes to address the prevalence of ‘risky’ behaviours and the persistence of stigma.
- Limited interventions that target attitudinal and behavioural changes.
- Limited consumer involvement in the development of HIV prevention strategies.
- Limited integration of alcohol and drug use issues with HIV prevention services. There is an unspoken assumption that Africans do not engage in drug use.

**‘New’ communities and the dispersal programme**

- Providers outside London reported that they have limited cultural competency and empirically based evidence of the HIV prevention needs of African communities.
- The dispersal programme has not been matched with appropriate investment (funding, research, staffing) to meet the complex HIV and sexual health prevention needs of dispersed Africans with HIV or vulnerable to HIV.
- There is limited knowledge about the needs of African students in and outside London. Although London is home to a significant number of African students, there is limited integration of HIV prevention services with educational institutions such as universities and colleges.
- A reported lack of clear guidelines regarding immigration rules and access to HIV treatment.
• Although health authorities outside London have been quick to respond to increasing numbers, there is limited regional collaboration and sharing of models of good practice.

Not using tradition in interventions

• Drama, music, conversations are not well integrated into HIV prevention services.
• Peer-led interventions given limited priority.
• Not integrating ‘reputable’ persons in HIV prevention interventions. These reputable persons include opinion leaders such as group leaders, DJs, religious leaders.

Gender-specific interventions

• Limited interventions specifically targeting sub-populations, including women and men who are HIV positive.
• The antenatal HIV testing programme, limited to pregnant women, at best results in slowing the acceleration of the HIV epidemic rather than absolute decreases.
• The needs of African gay men are largely unexplored. Some African gay men, in particular those outside London, are reported as not well integrated into services that target white or Caribbean gay men.

Limited grassroots marketing strategies

• Despite evidence of late presentations, the marketing of HIV prevention strategies tends to be focused on those who are already accessing services.
• There are limited grassroots approaches that target people in ‘isolated’ venues such as homes, hostels and other social structures frequented by Africans in England.
Recommendations

1. Increased sustainable funding and capacity building

- To cater for emerging populations outside London and to mobilise African communities.
- To develop a long-term pan-London funding strategy with rigorous monitoring and evaluation systems.
- Organisations should be diversifying their funding sources.

2. Encourage inter-agency collaboration

- To build the capacity of agencies outside the capital and share models of good practice.
- Partnerships with lay communities need to be supported and developed, to invest in strategies that ‘follow’ rather than congregate groups. Congregating groups (e.g. seminars) can exclude mobile populations (e.g. mini-cab drivers, students and asylum seekers).
- Collaborate with organisations targeting young people, men, families and women.

3. Improve the marketing of HIV prevention services

- Diversify the marketing strategies to include a grassroots focus to ‘follow’ the population.
- Sustained surveillance of new structures, sites, venues and settling patterns to inform the marketing strategies.
- Develop specific interventions that target high-risk groups including newly-arrived groups, students and those living with HIV.

4. Acknowledge traditional modes of communication

- Contextualise the word of mouth (drama, song and dance) in HIV prevention services.
- Invest (fund, train) in peer-led intervention and outreach work with the objective of embedding hard to reach communities into the collaborative partnership.
- The written word, for some communities, is reported as having limited impact due to language and literacy differences. There is a danger of HIV prevention literature being perceived as part of ‘official’ documentation by some groups.

5. Prioritise research

- Support for a national social research programme investigating the HIV prevention needs of African communities – sexual behaviours, sexual cultures in African communities.
- Set performance targets and indicators with commissioners ensuring that they promote appropriate diversity in research funding.
- Support for needs assessments of African communities in England using user-involvement models to capture the views of users and non-users of services.
- Systematic evaluation of the effectiveness of HIV prevention interventions.
- Qualitative research on the meanings of stigma and how best to address it.
1. Aims of this report

- To describe the types of service-providers that provide HIV prevention services to African communities in England.
- To present a summary of the key areas of activity and opportunities for the delivery of HIV prevention.
- To describe the challenges faced by providers of HIV prevention services.
- To identify priority needs of these services.

To achieve its set goals, the report will use the ASTOR format (Hickson, 1999) to describe the HIV prevention services aimed at African communities resident in England. The ASTOR format allows interventions to be described using the five headings listed in table 1 below. Hickson et al use this ASTOR framework to describe the health promotion activities in inner London targeting gay men.

Table 1: The ASTOR format

<table>
<thead>
<tr>
<th>Intervention description</th>
<th>What is intended to be changed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aim and intended outcomes</td>
<td>Where does the intervention take place? How do Africans come in contact with the intervention?</td>
</tr>
<tr>
<td>Setting (context)</td>
<td>Who is targeted by the intervention? Who do you not want to be exposed to the intervention?</td>
</tr>
<tr>
<td>Target group</td>
<td>What does the intervention consist of and how is it actually delivered?</td>
</tr>
<tr>
<td>Objectives and methods</td>
<td>What resources are needed? How do African communities define these resources needed to achieve the set aims and objectives?</td>
</tr>
<tr>
<td>Resources</td>
<td></td>
</tr>
</tbody>
</table>
2. Introduction and background

African migrant populations in the UK are the second largest social group affected by HIV and AIDS. The term ‘African’ is masked by cultural heterogeneity and migration histories. Some Africans are established in the UK, some are refugees, asylum seekers, students and others migrated for employment or family reunions. There are also marked diverse religious, educational and personal histories. There is evidence that for many Africans 'affected' by HIV, there are added concerns linked to social exclusion such as lack of citizenship and rights, racism, poor housing and higher levels of unemployment. The marginalisation of organisations that specifically target Africans is also noted (see Mukasa, 1999). Developing HIV prevention interventions that target such a diverse community is a challenge for providers who have to contend with the changing shape of the HIV epidemic and the diverse needs of recently arrived as well as settled communities.

There are evolving challenges currently facing providers of HIV prevention services within the context of health promotion\(^2\) to African communities. HIV in African communities is on the increase in London and outside the capital. There are increasing numbers of ‘new’ communities who are reported as affected by HIV and AIDS (e.g. West Africans, students, nurses, asylum seekers). The development of high cost medical treatments for AIDS-related complications has resulted in the redefining of AIDS from being an acute to a chronic condition, resulting in budget implications for care and primary prevention. In addition, the Immigration and Asylum Act (1998), in particular the dispersal programme, has led to the redistribution of African asylum seekers to areas which previously had limited HIV prevention services for this population. These changes are occurring amidst limited evidence of current HIV prevention services that are available to African communities in England.

There are a wide range of HIV prevention services based on various models of delivery (see Focus Consultancy, 1997). What is relatively unclear are the HIV prevention needs of African communities as well as the range of services currently on offer to African communities in England. This study aims to assess some of the issues facing providers and commissioners of current HIV health promotion services targeting African communities in England.

\(^2\) Health promotion is the process of enabling people to increase control over, and to improve their health. The Ottawa Charter identifies three basic strategies for health promotion and these are
- advocacy for health to create the conditions for health
- enabling all people to achieve their full potential and
- mediating between the different interests in society for the pursuit of health
3. The methodology

This section describes the methods used to collect the evidence presented in this report.

3.1 The steering group

To achieve its set aims, a steering group was set up to inform this study. The steering group offered advice, planned, monitored and evaluated the progress of the mapping exercise as well as the development of the *HIV Prevention and African Communities Living in England: A Framework for Action* and the literature review (Chinouya and Reynolds, 2001) that supports this work. The steering group was composed of representatives from the Department of Health, the African HIV Policy Network (AHPN), Public Health Laboratory Services, two persons living with HIV, three HIV prevention providers, a social researcher, two commissioners (from London and regional England) and Health Authority representatives. The work was led by National AIDS Trust (NAT).

3.2 The sampling frame

In order to reflect the spectrum of different organisations providing HIV prevention services to Africans, providers were drawn from:

- A range of provider organisations offering services to African communities with diverse leaderships: white-led organisations\(^3\), black-led organisations and African-led organisations.

The choice of which stakeholder to interview or engage in focus group discussions was informed and recommended by the HIV prevention specialists on the steering group. Priority was given to areas in Greater London, Manchester, Leeds, Birmingham and other areas which were targeted for the dispersal of refugees and asylum seekers under the Immigration and Asylum Act (1998).

3.3 Interviews and focus groups

Interviews and focus group discussions were held with providers of HIV prevention services in community-based organisations (CBOs), voluntary and statutory organisations, and HIV commissioners. Representatives from each of the eight London forums, the Northern forum and the Midlands African forum took part in focus group discussions.

3.4 Research tools

\(^3\) The terms ‘white-led’, ‘black-led’ and African-led are historical social constructs, a result of the shape of the UK HIV epidemic (initially a ‘gay disease’, later to reconstruct itself as also an African ‘heterosexual disease’) had affected organisational development in England. White gay men who aimed at meeting the needs of white gay men initially formed the white-led organisations. Such organisations were historically characterised by white managers and predominantly a white management committee. African-led organisations are/were formed by Africans who were aiming to meet the HIV prevention needs of African communities. These African-led organisations are characterised by a predominantly African management committee and black African managers. This is not to render the words ‘African’ ‘black’ and ‘white’ as unproblematic. There are reports of some white Africans accessing services from African-led or black-led agencies. A common feature of white-led agencies is that they have matured and cater for the HIV promotion needs of black and white clients.
A topic guide was formulated by the steering group and shaped the researcher’s constructions of the qualitative in-depth questionnaire. A focus group schedule, whose topics closely matched those covered by the questionnaire was also constructed by the researcher. A qualitative approach was chosen as this allowed in-depth exploration of the questions and meanings related to the exercise.

3.5 Telephone interviews and focus groups

- The use of telephone interviews (N=21) and focus group discussions allowed us to explore services available to African communities in addition to those offered by the respondents.
- The questionnaire was administered through one-to-one telephone interviews, which lasted an average of 40 minutes. The use of telephone interviews was based on pragmatism - experience has shown that there are low rates of returns of in-depth postal questionnaires. This reflects how organisations aim to use their limited resources (e.g. time and labour) effectively, rendering a research agenda secondary to organisational imperatives.
- Two audio-taped focus groups (with 10 representatives) were conducted in separate geographical locations (London and regional England). The use of focus groups was also based on pragmatic issues of time and costs. Focus group discussions allowed representatives from a wide geographical area to come together, at particular times, to discuss issues related to the social mapping exercise.

3.6 Limitations of this study

This report is based on the ways a sample of service providers made sense of and interpreted the range of HIV prevention services available to their clients, limitations of these services and their recommendations for improvement. The study does not address the experiences of the targeted African communities about HIV prevention services available to them. There were only 31 service providers out of the many consulted, a result of limited resources - namely time and money. This study is therefore a snapshot account of services that are currently on offer to African communities.
4. Organisations engaged in this study

31 representatives of organisations were consulted. They are listed in Appendix A. Respondents were asked ‘how would you describe your organisation?’. 

- 42% described themselves as health authority agencies
- 32% African-led
- 16% were white-led
- 10% black/ethnic minority led.

Nearly all African-led and white-led non-health authority agencies identified themselves as registered charities with few reporting being a community/voluntary organisation. Black/ethnic minority groups were more likely to identify themselves as community/voluntary agencies. There were different organisational identities reflecting different target populations:

- National-specific agencies providing HIV prevention services to those who identified themselves as members of a particular nationality.
- Pan-African agencies providing HIV prevention services to any member of the African community. All white-led charities and health authorities identified themselves as offering services to all African.
- Black/ethnic minority agencies providing services to black communities including Africans.

There are differences that exist amongst agencies that report that they are national-specific, pan-African and black and ethnic minority agencies. These differences are outlined below:

- National-specific agencies tend to be in the early phases of organisational development.
  - Nearly all national-specific agencies were poorly-resourced.
  - Pan-African agencies were more organisationally developed and mature than national-specific organisations.
  - Some national-specific agencies provided services to ‘all Africans’ (due to increased demands) amidst limited resources, raising questions about the quality of the interventions delivered.
  - Providers outside the capital did not specifically target Africans but rather all black and ethnic minority populations, including Africans.

4.1 The range of services

This section describes the range of HIV prevention services identified by the service providers and the stated aims of such interventions.

4.2 Aims and objectives of the interventions

All the providers are aiming to reduce the acquisition and transmission of HIV infection among African communities living in England. Specific stated objectives were:

- To reduce the transmission of HIV among sexual partners.
- To reduce vertical transmission of HIV from mother to baby.
- To improve the quality of life of those who are living with HIV and reduce the complications brought by HIV/AIDS to those who are infected.
- To promote social inclusion.

None of the providers mentioned reducing transmission of HIV through needle sharing. To achieve their set goals, there was a synergy of aims and delivery modes with the statutory and voluntary organisations, and community based agencies and charities engaged in building the
capacity of each other. Capacity building was a shared goal with community-based agencies or charities often providing training to workers in the statutory sector on how best to meet the HIV prevention needs of African communities. Providers in London reported this trend more often. However there is limited evidence of how the HIV prevention needs of African communities were identified by key stakeholders and what empirical evidence had informed the training and collaboration.

4.3 HIV prevention services

A range of HIV prevention interventions were identified and this included provision of information, needs assessments, advocacy, developing culturally sensitive resources, care, research and evaluation and developing community based interventions. Although these services appear distinct, their boundaries are fluid.

Information

- Basic HIV awareness to the general African population or volunteers.
- Training.
- Condom distribution, with femidoms mentioned less.

Needs assessment/referrals

- Individual needs assessment for those living with, or suspecting that they are HIV positive.
- Referrals to appropriate agencies.
- In primary prevention, individual needs assessment was not conducted, with information and condoms distributed regardless of expressed need.
- There are indications that agencies place emphasis on meeting the social care needs of individuals living with HIV/AIDS, with less priority for the untested, HIV negative or those not accessing services.

Advocacy

- This involved lobbying for services aimed at enhancing the users (mostly HIV positive) self esteem and personal growth by addressing their medical, social, legal and economic circumstances.

Developing culturally sensitive resources

- The words ‘culturally sensitive’ refers to the development of resources (including leaflets) that take account of diversities such as language differences, practices and the use of images perceived as ‘non-provocative’. Leaflets developed covered topics such as treatments and available services.
- These were usually commissioned to agencies with a pan-African remit, working collaboratively and in consultation with some national-specific charities in developing the resources.
- There were concerns that some resources developed in London could not easily ‘fit’ with some situations outside London.

Care

- Care (practical and emotional help) was predominately offered by agencies whose clients had a known HIV diagnosis.
- Findings suggest that agencies offering practical care were also engaged in emotional support, thus intensifying the care burdens of volunteers and carers.
Research, monitoring and evaluation

- All agencies were often engaged in research, in most cases as participants.
- Monitoring and evaluation was conducted routinely, usually after a one-off event.
- Limited strategies monitored the long-term success of interventions.

Facilitating the development of community-based initiatives.

- Findings suggest that these interventions were most often initiated by the statutory sector, (working in partnership with charities, CBOs and voluntary agencies) providing in most cases short-term funding for community-based initiatives to be implemented.

4.4 Settings: where the interventions are delivered

- One to one/individually tailored HIV prevention interventions (e.g. in homes).
- Community HIV prevention strategies (e.g. workshops, seminars, world AIDS day events and health days).
- Social networking/outreach work: e.g. workers or volunteers networking in various social venues providing HIV prevention resources on a one to one basis or with groups.
- Organisational HIV prevention days - this included training other providers.
- Lobbying for the improvement of the development of HIV prevention services and policies.

4.5 Who is targeted?

- White-led agencies, health authorities and pan-African agencies reported that they provided services to all Africans, regardless of ethnic or national identities.
- Ugandan-led organisations have matured and described their target population as ‘pan-African’.
- National specific communities targeting Africans from individual countries. For some, their historical and personal backgrounds ‘back home’ had blurred the national or country specific identities.
- Some reported gender specific interventions.

4.6 Gaps in services

The distribution of asylum seekers under the dispersal programme has increased the numbers of Africans in health authority boundaries that are not currently delivering targeted HIV prevention services to this new population. In addition to the increased numbers of asylum seekers, students and other communities from high-risk countries are living outside London. There are reports outside the capital that some Africans often present late and with higher viral loads. Inappropriate accommodation was of concern. Some newly arrived communities are living in sub-standard housing often characterised by overcrowding. There are fears of tuberculosis outbreaks in these sub-standard houses, hostels and detention centres.

The increasing numbers of students and asylum seekers outside London has not been matched with appropriate investment (funding, training, and secondment of African staff). The views of agencies from London and outside London are contrasted in table 2

<table>
<thead>
<tr>
<th>Table 2: Concerns from London and outside the capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concerns from outside London</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>efforts to reach students at Fresher’s Fairs need to be sustained</td>
</tr>
<tr>
<td>Some HIV prevention information being disseminated through international student bodies</td>
</tr>
<tr>
<td>the dispersal programme creates difficulties in reaching communities as settlement</td>
</tr>
</tbody>
</table>
patterns are relatively unknown
• outbreaks of tuberculosis in some hostels due to inappropriate accommodation

• health authority boundaries geographically large
• health authority boundaries limit the sustainability of interventions due to inter-borough movements

• limited integration of HIV prevention and alcohol and drugs interventions
• limited integration of HIV health promotion and alcohol and drugs interventions

• fewer agencies specifically target Africans
• unfounded (un-researched) concerns that there are too many African HIV charities

5. Inter-Agency collaboration - ‘working together’

Why collaborate?

A number of factors facilitated inter-agency collaboration and these are listed below.

• A need for an integrated approach which maximised benefits. Agencies reported partnership with non-HIV specific agencies was important to achieve community and individual empowerment objectives.
• To avoid duplication. This was reported mostly by London based agencies.
• To utilise established community networks for accessing groups which statutory agencies and charities with a pan-African remit find hard to reach.
• Shared aims and inter-agency referrals.
• To share resources and build on the strengths of well-funded and established agencies.
• To empower organisations through information, lobbying and networking.

Despite these strengths, there were reported dangers of inter-agency collaboration.

Dangers of collaboration

• Inter-agency collaboration could be detrimental during an organisation’s infancy stage. There was a perceived danger of being ‘swallowed’ by well-funded and established agencies.
• There were reports of ‘token collaboration’, with less consultation of less funded agencies by their larger established partners.
• There were concerns that some well-established agencies claimed to be ‘the voice’ for African communities, without acknowledging the diversities that exist.
• It was reported that although there are some African-led organisations outside London, HIV prevention is not their priority and inter-agency collaboration could have limited impact if not matched by capacity building of non-HIV prevention agencies.

Enhancing collaboration

Respondents were asked to suggest ways in which inter-agency collaboration could be enhanced. The recommendations proposed by providers are:

• Capacity building supported by regional and pan-London funding.
• Build on the strength of HIV prevention forums and the African HIV Policy Network to build more linkages with organisations. Encourage various stakeholders to ‘speak with one voice’.
• Conduct a needs assessment to identify the needs of various stakeholders on how to work together effectively. The needs assessment would create an enabling environment (e.g. trust and transparency) and set the stage to define clear priorities, aims, objectives roles and responsibilities.
- Build the capacity of non-HIV specific organisations and address the stigmatised nature of HIV, African communities and asylum seekers.
6. Marketing HIV prevention services

Providers were asked how they marketed their services. A range of marketing strategies was employed, informed by the organisation’s HIV prevention objectives (i.e. primary or secondary prevention or both). These are outlined in table 3 below.

**Table 3: Marketing services - methods**

<table>
<thead>
<tr>
<th>Primary HIV prevention</th>
<th>Secondary HIV prevention</th>
<th>Combined primary and secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home visits (sessional workers or volunteers)</td>
<td>Through hospitals and GUM clinics</td>
<td>Advertise in magazines such as <em>Positive Nation, Foundation News</em></td>
</tr>
<tr>
<td>Telephoning using information from database</td>
<td>Leaflets distributed through partner organisations</td>
<td>Posters/flyers distributed to health Authorities, GUM clinics etc.</td>
</tr>
<tr>
<td>Word of mouth</td>
<td>Word of mouth</td>
<td>Word of mouth</td>
</tr>
<tr>
<td>Community events (football, barber shops, churches)</td>
<td></td>
<td>Radio (Health Africa), TV documentaries</td>
</tr>
<tr>
<td>Advertising in HIV newsletters</td>
<td>Computer based websites HIV newsletters</td>
<td>Advertising in HIV newsletters</td>
</tr>
</tbody>
</table>

**Gaps in marketing**

- As noted from the table above, one has to be in contact with agencies to be on an organisation’s database, to be telephoned, visited or indeed be aware of HIV publications. A potential client also has to know someone who is in contact with the agencies for the word of mouth to be effective.
- Few agencies targeted student populations.
- African communities are highly mobile. Limited sustained social mapping of African communities with the objective of exploring where new communities are settling, and socialising.
7. Evidence-based interventions?

Evaluating HIV health promotion services targeting African communities supports effective and consistent practice and encourages a culture of reflexivity within organisations. Many Africans community organisations are undertaking innovative and excellent interventions with various communities. Funders and providers of African HIV health promotion services need to foster a commitment to evaluate the impact of these interventions. There has been little systematic evaluation of HIV prevention work targeting African communities (Bhatt, Phellas and Pozniak, 2000).

Many providers are planning and delivering interventions based on scant knowledge of HIV prevention need in target populations. The absence of systematic national data on sexual behaviour and sexual cultures in African communities weakens a lot of the work and undermines government objectives to promote effectiveness in HIV prevention.

Despite the variety of attempts at reducing the acquisition and transmission of HIV among African communities, reports of increasing numbers of Africans acquiring or transmitting HIV challenge our sense of the effectiveness of current interventions. At a national level, increasing HIV rates were reported by providers as reflecting the success of the HIV antenatal testing programme which although it has prompted a rise in new diagnoses amongst African communities, has also led to a reduction in numbers of HIV positive infants.

Agencies outside London reported a lack of clarity on how immigration regulations affected access to treatment. This was problematic in giving advice on testing. A key question for many providers as they approach interventions focusing on HIV testing is, if a community member with unresolved immigration status tests HIV positive, would s/he have rights to HIV treatment?

Why agencies use particular methods

When asked what evidence had influenced their HIV prevention strategies nearly all agencies reported more than one source of evidence as outlined below.

- Word of mouth - based on what other people were saying.
- Don’t know - not knowing what evidence had informed their HIV health promotion interventions.
- Reactive - this was based on anecdotal evidence gathered by workers, such as number of people who were perceived as having AIDS related illnesses or had died from AIDS.
- User involvement - engagement of users in assessments, sexual history taking.
- Monitoring and evaluation – data gathered from monitoring forms after service delivery.
- Research – responding to research findings relating to African communities.

There are indications that a majority of African-led agencies had used a reactive approach in developing services. There were also reports that some agencies had transplanted methods used for gay men directly onto African communities, without establishing what the needs and models of good practice for African communities are.

The limited use of research by agencies, to inform HIV prevention interventions, reflects the lack of substantial investment in HIV social research with African communities.

Some agencies report a user-involvement model, with clients engaged in setting the agenda of what needs to be done. The effectiveness of this approach is unknown.

Evaluating interventions
Respondents were asked how they measured the effectiveness of their HIV prevention interventions. The methods identified were:

- Surveys - agencies conducted research about their services.
- Not sure - lack of clarity on how services were evaluated.
- Word of mouth - comments or conversations with clients.
- Monitoring and evaluation – predominantly surveys of feedback on services.
- Reports - internal or external (conference reports, personal accounts, newsletters) about the responses from African communities to HIV prevention interventions.

Results about how agencies used the above strategies to measure the effectiveness of their services are shown in figure 4.

**Fig 1: Methods used to measure the effectiveness of interventions**

Priority needs

If good practice is to be maintained and sustained there is a need to critically contextualise verbal communication as a resource in HIV prevention. This could involve an investment in sustainable peer-led interventions, coupled with rigorous monitoring and evaluation.

Agencies reported that at times funders prescribed HIV prevention strategies with limited evidence about the effectiveness of such interventions. There were reports of seminars and workshops attended by participants who were well informed or a 'converted crowd'.

There are indications that there is a need to invest in outreach work, targeting Africans who may not normally access services. There was an identified need to target and have sustainable interventions with people such as housepersons, nurses, mini-cab drivers, hairdressers (salon and home based), carers, chambermaids, students, markets etc. Although some outreach work is conducted by agencies, this is not sustained, due to limited resources and limited rigorous monitoring and evaluation.
8. Funding HIV prevention interventions

Data indicated that a majority of community organisations received funding from health authorities (42%), local authorities (33%), with fewer reporting funding from the national lotteries (17%) and other sources (8%). This could suggest a reliance on health/statutory sector funding or difficulties of securing ‘alternative’ funding.

Financial constraints

- Funding was unsustainable resulting in investing in one-off interventions with unknown effectiveness.
- The under-representation of Africans in strategic policy making positions was perceived as limiting ‘African voices and concerns’ in HIV commissioning.

When asked if they faced barriers in securing funding, all (100%) community/voluntary and registered charities reported that they did. There were various perceived reasons for such difficulties and these are summarised with recommendations from the respondents (see figure 5).

Table 5: Funding difficulties and possible solutions

<table>
<thead>
<tr>
<th>Identified difficulty</th>
<th>Possible solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>In London, there is a perception that there are too many African-led organisations and funders are reluctant to fund due to perceptions of duplication</td>
<td>Each organisation sees itself as unique but we need to prove our uniqueness and quality of work/effectiveness and appropriateness</td>
</tr>
<tr>
<td>Reported by relatively newly formed organisations: lack of knowledge on how and who to approach for funding</td>
<td>Workshops to help new organisations improve skills on how to develop effective proposals</td>
</tr>
<tr>
<td>Racism: Some funding organisations are perceived as not having confidence in funding African-led organisations</td>
<td>Try to get patrons who are known in the community, but some potential patrons not interested in supporting smaller African led organisations</td>
</tr>
<tr>
<td>Cycle of under-funding impacting on lack of personnel. Working with volunteers who have a high turnover rate</td>
<td>Make funds available for personnel and other resources. Organisations should develop strategies for independent fund-raising</td>
</tr>
<tr>
<td>Lack of sustainable funds</td>
<td>Move to ‘real’ and flexible partnership with funders and health authority</td>
</tr>
</tbody>
</table>

The Commissioners’ perspectives

The views of commissioners varied, reflecting their respective health authorities and the demographic characteristics of the African population in their catchment areas. The following represent key themes emerging from the commissioners:

- The costs of combination therapies are having a knock-on effects on primary prevention budgets (this was particularly so for London).
Some commissioners reported that some agencies are not particularly keen to apply for the small grant scheme, a possible result of its lack of sustainability.

There is need for an integrated pan-London development with cross-district funding.

There is a need for transparency between commissioners and providers of HIV prevention, a transparency that allows for dialogue, bringing together various stakeholders but also acknowledging diversities and differences.

Commissioners outside London reported the following issues as problematic:

- Lack of local expertise and patchy responses to the increase.
- African communities were 'invisible'. It was costly to fund African specific projects targeting small numbers.
- There were reported large numbers of 'Africans' in regional areas, but smaller 'national' numbers, resulting in it being costly to focus on country specific communities. The dilemma faced was how to capture diversity in commissioning.
- Lack of evidence to inform health promotion strategies. Some health authorities reported that they had just initiated needs assessment exercises to inform their work.
- Few (or none in some cases) agencies targeting African communities.
9. Barriers to effective HIV health promotion

This section examines barriers to effective health promotion. In outlining the barriers to effective HIV health promotion, the eight point review of effectiveness in health promotion will be used (Oakley, 1995).

1. Sustained interventions are likely to lead to sustained behaviour change
2. Work at community level can at times lead to significant changes in behaviour
3. Cultural competency
4. Interventions with Individuals can lead to behaviour change but not in high prevalence populations
5. Counselling and testing have a place in reducing risk but not sufficient for prevention
6. HIV prevention should be part of a broader spectrum of sexual health
7. Media interventions can sometimes lead to general population behaviour changes
8. Availability of condoms, needles and syringes reduces the risk of infection

Are interventions sustainable?

There is evidence suggesting that interventions targeting African communities lack sustainability, a product of the nature of funding HIV services (e.g. the small grant scheme, World Day events, seminars, workshops). Financial constraints were reported by all non-health authority agencies. Lack of funding resulted in staffing shortage amidst increasing numbers of clients. The dispersal programme in addition to isolating individuals, suggest that individuals are constantly on the move. Some sub-populations affected by HIV and AIDS in England are highly mobile (e.g. students, refugees and asylum seekers, visitors).

Work at community level can sometimes lead to significant changes in behaviour

Services were based on limited research about the HIV prevention needs of African communities. There was limited information on the settlement patterns of African communities outside London, limiting community-based initiatives.

Cultural competency

London-based agencies reported that their most important resource was cultural competence and an awareness of the cultural practices placing their communities at risk of HIV. Cultural competency was also demonstrated in the production of resources. Agencies outside London reported lack of cultural competency. Some providers reported that they did not have expertise on African cultural issues. Preliminary work has shown that there are large numbers of students and trainee nurses in the Midlands, with a vast majority of them from Botswana, South Africa, Zambia and Zimbabwe where the HIV prevalence was in excess of 25% (Chikobvu, 2000).

Interventions with individuals can change behaviour, but not reduce risk

Nearly all agencies provided information on HIV awareness and condoms. Few agencies provided interventions in people’s homes, or targeting communities most at risk of HIV. Most agencies reported providing interventions to groups, (workshops, seminars, community events). However they were reports that at times health authorities were prescriptive in their approach, with emphasis placed on information giving. There was limited focus on changing attitudes and behaviours. There were reports that despite high levels of HIV awareness for some communities affected by HIV, risky behaviours were prevalent, with some providers suggesting a need to invest in re-evaluating their strategies.

Counselling and testing have a place in reducing risk but not sufficient for prevention.
Despite some popular beliefs that counselling is ‘unAfrican’ there are indications that counselling women in antenatal care has been successful. This is shown by the numbers of women who have taken up the service and received interventions to minimise vertical transmission. At a population level, this strategy is limited as it targets only women. The strategy can decrease acceleration rather absolute numbers and should be part of the wider spectrum of HIV prevention services.

**HIV interventions programmes should be part of a broader spectrum of sexual health**

The National Sexual Health and HIV Strategy seeks to contextualise HIV within the broader spectrum of sexual health interventions that includes teenage pregnancies and other sexually transmitted infections. There is a need to acknowledge the particular concerns faced by African communities which may hinder the access to HIV prevention services and other screening services.

**Media interventions can sometimes lead to general population behavioural changes**

Few publications and radio programmes specifically address the HIV prevention needs of the general African population. The few available need more marketing to reach the general African population.

**Availability of condoms, needles and syringes reduces the risk of infection**

Nearly all agencies reported that they provide a condom distribution service. The levels of drug use within African communities is unknown, subsequently leading to limited interventions that focus on needle distribution. The focus on condoms (with limited education on how to use femidoms) is however gender biased, with women at times limited in their capacity to negotiate for safer sex.
Bibliography


**Appendix A: Organisations engaged in the study**

1. African Community Involvement Association  
2. African Cultural Promotions  
3. Agency for Culture and Change Management  
4. African HIV Policy Network  
5. Black HIV and AIDS Forum  
6. HIV and AIDS Association of Zambia  
7. HIV Response Project  
8. George House Trust  
9. Innovative Vision  
10. Freshwinds  
11. London Ecumenical AIDS Trust  
12. Kenya Care Services  
13. Pamodzi  
14. Uganda AIDS Action Fund  
15. Terrance Higgins Trust, Birmingham  
17. Birmingham Specialist Community Health  
18. Hammersmith, Fulham, Ealing and Hounslow Health Authority  
19. Kensington, Chelsea and Westminster Health Authority  
20. Newham NHS Trust  
21. Barking, Havering and Dagenham NHS Trust  
22. Lambeth, Southwark and Lewisham community Trust  
23. East Surrey Health Authority  
24. Enfield and Haringey Health Authority  
25. Leeds Health Authority  
26. West Surrey Health Authority  
27. African Healthcare and Counselling Services  
28. Lambeth Southwark and Lewisham NHS Trust  
29. Ethiopian Health Support Association  
30. Barnet Health Authority  
31. Camden and Islington Health Authority